HIE Steering Committee

Claims Pilot Subcommittee

Meeting #3 - April 16th, 2021

Agenda

- Review New Use Cases: Medicaid Payment Reform
- Next Steps

Role of Subcommittee Members Re: Use Cases

- Learn about each of the use cases presented by fellow subcommittee members
  - What is the user trying to accomplish? What do they need?
- Weigh in: support editing, culling, prioritizing
  - How could this be augmented to be clearer? Is it missing anything? Where does this fit in your sense of priorities?
- Support assessment of technical feasibility by VITL and MMIS partners

Use Case Categories - Definition

- Clinical uses – Individual:
  - These use cases focus **on how data/information is used in a clinical setting to support clinical decisions** made **between an individual and their provider**.
- QI/operational - Organization:
  - These use cases focus **on how data is used by an organization** and can be grouped into two categories. 1) How a health care organization uses data **to improve its processes/workflow** and improve panel management for groups of patients. 2) How a program uses data **to enhance operations** such as setting payment levels for value-based payments or making policy decisions on how the program operates.
- Evaluation – Population health:
  - These use cases focus on whether a program, policy, or intervention achieved what it meant to achieve. The **outcomes are used to support decision making**; can be more dynamic and flexible that reporting, though often rely on similar nationally recognized measures; see below.
- Reporting – Population Health:
  - These use cases are **measures** often agreed upon at the beginning of a program/ agreement/demonstration **to be monitored by an overseeing entity**, e.g., the federal government. Generally, these measures are drawn from nationally recognized measures.

Use Cases from Interview #2

Determine payments made to providers participating in Medicaid value-based payment arrangements (Part 1)

USER STORY

Actors: OCV (ACO) DVHA and its Payment Reform Unit, other State Government Staff and Contractors, Providers (including provider organizations), ACOs (currently OneCare Vermont), Green Mountain Care Board, Federal Government Staff and Contractors, Public, Media, Consumer Advocates

As a DVHA Payment Reform Program Lead,
I want to use Clinical, and Claims Data linked at the person level to calculate the outcomes of quality measures to which value-based payments are tied in various Medicaid alternative payment models. Mechanisms for tying payments to quality outcomes include determining the final payment amount based on quality outcomes or withholding a portion of the payment that will be paid out depending on the outcomes of the quality metrics. The VMNG uses the latter approach. (As an aside, the Blueprint for Health uses the former approach). Examples of measures currently used in the VMNG program to assess the value-based payment amount include Hypertension in Control and Diabetes in Poor Control, although there are many other measures used by various alternative payment model programs. In the example of the VMNG, how well the Accountable Care Organization succeeds in attaining established benchmarks for these metrics of population health will affect the portion of value-based payment they receive under the terms of the VMNG contract.

In addition to the VMNG example, the Payment Reform Unit designs, implements, operates, and evaluates other alternative and value-based payment models for health and human services programs operating across the AHS. These include:

- Adult and Children's Mental Health Payment Reform
- Applied Behavior Analysis Payment Reform
- Residential Substance Use Disorder Treatment Payment Reform
- Children's Integrated Services Payment Reform
- Developmental Disabilities Services Payment Reform
- Adult and Children's High-Technology Nursing Services Payment Reform

USE CASE: QI/Operations – Organization

Determine payments made to providers participating in Medicaid value-based payment arrangements (Part 2)

ORGANIZATIONS

- The Department of Vermont Health Access within the Agency of Human Services is the administrator of a large portion of payments to providers of health care and human services for Medicaid enrolled Vermonters. The Payment Reform Unit at DVHA partners with programs across the AHS to design and implement alternative payment models for Medicaid covered health and human services.
- Providers produce claims data through the course of billing for health care and human services rendered to Medicaid members.
- DVHA's payment reform unit will consume the clinical and claims data to evaluate, operate and report on Medicaid's alternative and value-based payment programs.

GOAL

- Design and implement alternative and value-based payment models that incentivize quality improvement and increased value in service delivery to Medicaid members

TRADING PARTNERS AND SYSTEMS

- MMIS (Claims Data) – SOURCE of data
- Gainwell - Vermont MMIS Vendor – PROCESSOR and AGGREGATOR of data
- OneCare Vermont ACO) – SOURCE of clinical data and CONSUMER of claims and eligibility data
- Clinical Data captured by State Program Staff (e.g., Monthly Service Report (MSR)) – SOURCE
- Federal Agencies (e.g., Centers for Medicare and Medicaid Services (CMS), Center for Medicare and Medicaid Innovation (CMMI), Substance Abuse & Mental Health Services Administration (SAMHSA)) – SOURCE and CONSUMER of data
- State Agencies (e.g., Department of Mental Health; Department of Disabilities, Aging, and Independent Living; Division of Alcohol and Drug Abuse Programs) – SOURCE and CONSUMER of data
- Analytics contractors (e.g., Wakely, Health Management Associates) – SOURCE and CONSUMER of data
- Business Objects, a tool to analyze claims data feeds from the MMIS.
- SPSS, SAS, and other statistical analytics tools

CHALLENGES/PAIN POINTS

- Integrated claims and clinical data could allow us to calculate results for hybrid quality measures (e.g., HbA1c Poor Control, Controlling High Blood Pressure, Screening for Clinical Depression and Follow-Up Plan). Currently, we provide random samples to the ACO. The ACO and its participating providers have to conduct medical record review.

DATA TO EXCHANGE

- Claims data (current and historical)
- Clinical data (current and historical)
- Social Determinants Of Health (SDOH) Data
- Eligibility & Demographic Data

DATA GOVERNANCE

- HIPAA
- VHIE Patient Consent Policy – Clinical
- VHIE Patient Consent Policy – Claims
- Vermont Medicaid Next Generation (VMNG) Opt-Out Process
- VMNG Operations Manual, Reporting Manual & Contract
- 42 CFR Part 2
- Vermont All-Payer Accountable Care Organization (ACO) Model Agreement with CMS

FREQUENCY

- Annual (from OCV to DVHA), for calculating clinical based quality measures for VMNG ACO Program
- Weekly (from DVHA to OCV) Claims Extract for VMNG ACO Program monitoring and operations

USE CASE TARGET DATE

- Annual (from OCV to DVHA), for calculating clinical based quality measures for VMNG ACO Program
- Weekly (from DVHA to OCV) Claims Extract for VMNG ACO Program monitoring and operations

MMIS DATA PIPELINE (Source)

<Check with Technical team>

DATA FORMAT (Source to VHIE)

<Check with Technical team>

TRANSPORT MECHANISM

<Check with Technical team>

DATA RECIPIENT FORMAT (VHIE to End User)

<Check with Technical team>

CONSENT SPECIFICATIONS

VMNG Opt-Out

LEGAL AGREEMENTS

ACO & their Member (Provider) Contracts
Business Associate Agreement (BAA) for VITL - DVHA

AHS/DVHA Payment Reform Alternative Payment Model Program Monitoring and Reporting (Part 1)

USER STORY

Actors: OCV (ACO) DVHA and its Payment Reform Unit, other State Government Staff and Contractors, Providers (including provider organizations), ACOs (currently OneCare Vermont), Green Mountain Care Board, Federal Government Staff and Contractors, Public, Media, Consumer Advocates

As a DVHA Payment Reform program lead,
I want to use clinical and claims data linked at the person level to calculate quality measure results to determine value-based payments in various Medicaid alternative payment models. Mechanisms for tying payments to quality results include determining final payment amounts based on quality results or withholding a portion of the payment that will be paid out depending on quality results. The VMNG uses the latter approach; the Blueprint for Health uses the former approach. Examples of measures currently used in the VMNG program to determine value-based payments include Controlling High Blood Pressure and HbA1c Poor Control for People with Diabetes. There are many other measures used by various alternative payment model programs. In the VMNG example, how well the ACO succeeds in attaining established benchmarks for these quality measures will affect the portion of value-based payment the ACO retains under the terms of the VMNG contract.

In addition to the VMNG example, the Payment Reform Unit designs, implements, operates, and evaluates other alternative and value-based payment models for health and human services programs operating across the AHS. These include:

- Adult and Children's Mental Health Payment Reform
- Applied Behavior Analysis Payment Reform
- Residential Substance Use Disorder Treatment Payment Reform
- Children's Integrated Services Payment Reform
- Developmental Disabilities Services Payment Reform
- Adult and Children's High-Technology Nursing Services Payment Reform

USE CASE: Reporting - Population

AHS/DVHA Payment Reform Alternative Payment Model Program Monitoring and Reporting (Part 2)

ORGANIZATIONS

- The Department of Vermont Health Access within the Agency of Human Services is the administrator of a large portion of payments to providers of health care and human services for Medicaid enrolled Vermonters. The Payment Reform Unit at DVHA partners with programs across the AHS to design and implement alternative payment models for Medicaid covered health and human services.
- Providers produce claims data through the course of billing for health care and human services rendered to Medicaid members.
- DVHA's payment reform unit will consume the clinical and claims data to evaluate, operate and report on Medicaid's alternative and value-based payment programs.

GOAL

- To meet various reporting requirements (whether State, Federal, or from other stakeholders) and support program monitoring, accountability, and transparency.

TRADING PARTNERS AND SYSTEMS

- MMIS (Claims Data) – SOURCE of data
- Gainwell - Vermont MMIS Vendor – PROCESSOR and AGGREGATOR of data
- OneCare Vermont ACO) – SOURCE of clinical data and CONSUMER of claims and eligibility data
- Clinical Data captured by State Program Staff (e.g., Monthly Service Report (MSR)) – SOURCE
- Federal Agencies (e.g., Centers for Medicare and Medicaid Services (CMS), Center for Medicare and Medicaid Innovation (CMMI), Substance Abuse & Mental Health Services Administration (SAMHSA)) – SOURCE and CONSUMER of data
- State Agencies (e.g., Department of Mental Health; Department of Disabilities, Aging, and Independent Living; Division of Alcohol and Drug Abuse Programs) – SOURCE and CONSUMER of data
- Analytics contractors (e.g., Wakely, Health Management Associates) – SOURCE and CONSUMER of data
- Business Objects, a tool to analyze claims data feeds from the MMIS.
- SPSS, SAS, and other statistical analytics tools

CHALLENGES/PAIN POINTS

- Integrated claims and clinical data could allow us to calculate results for hybrid quality measures (e.g., HbA1c Poor Control, Controlling High Blood Pressure, Screening for Clinical Depression and Follow-Up Plan). Currently, we provide random samples to the ACO. The ACO and its participating providers have to conduct medical record review.

DATA TO EXCHANGE

- Claims data (current and historical)
- Clinical data (current and historical)
- Social Determinants Of Health (SDOH) Data
- Eligibility & Demographic Data

DATA GOVERNANCE

- HIPAA
- VHIE Patient Consent Policy – Clinical
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- 42 CFR Part 2
- Vermont All-Payer Accountable Care Organization (ACO) Model Agreement with CMS

FREQUENCY

- Varies for each program and report; some are ad-hoc

USE CASE TARGET DATE

- As early as possible

MMIS DATA PIPELINE (Source)

<Check with Technical team>

DATA FORMAT (Source to VHIE)

<Check with Technical team>

TRANSPORT MECHANISM

<Check with Technical team>

DATA RECIPIENT FORMAT (VHIE to End User)

<Check with Technical team>

CONSENT SPECIFICATIONS

VMNG Opt-Out

LEGAL AGREEMENTS

There are typically separate Contracts or Grants for each alternative or value-based payment program.

Discussion/Feedback

Debrief with Erin F. & Pat J. on Use Case Gathering Process

- What did you do to prepare?
- What helped you successfully participate in the process?
- What went well?
- What can be improved?
- What should others expect?

Use Cases Summary

Category	Use Case Name	Stakeholder
Clinical - Individual	Prescription Reconciliation, Fulfillment Monitoring	Mary Kate Mohlman
Clinical - Individual	Validate the Service Provided	Mary Kate Mohlman
QI/Operations - Organization	Panel Management of Individuals with Chronic Conditions– identifying those whose conditions need better management	Mary Kate Mohlman
Evaluation - Population	Assessing Quality Improvement Initiatives on Hypertension Control and Outcomes	Mary Kate Mohlman
Reporting - Population	Percent of population with H*ypertension in control and Diabetes in poor control*	Mary Kate Mohlman
QI/Operations - Organization	Improving support and Care management for individuals with Hypertension and Diabetes in the State	Katelyn Muir
QI/Operations - Organization	Improve Immunization Rate	Katelyn Muir
Evaluation - Population	Evaluating the Clinical impact of the Care Coordination Model	Katelyn Muir
Evaluation - Population	Evaluation of primary prevention by Health Service Areas (HSA)	Katelyn Muir
QI/Operations – Organization	Determine payments made to providers participating in Medicaid value-based payment arrangements.	Pat Jones Erin Flynn
Reporting - Population	AHS/DVHA Payment Reform Alternative Payment Model Program Monitoring and Reporting	Pat Jones Erin Flynn

Next Steps

Use Case Gathering Sessions

#	Interview	Focus of Discussion	Schedule & Status
1	**Katie Muir**, *OneCare VT*	• Evaluation & Reporting of the APM • Support of clinical practices and the care model	**3/3/2021 – Completed**
2	**Pat Jones**, *DVHA Payment Reform* **Erin Flynn**, *DVHA Payment Reform*	• Evaluation & Reporting of the APM • Support of clinical practices and the care model	**3/30/2021 – Completed**
3	**Ben Green**, *Blue Cross Blue Shield* **James Mauro**, *Blue Cross Blue Shield*	• Commercial Claims	**4/19/2021 – Scheduled**

4	**Sarah Lindberg**, *Green Mountain Care Board*	• Analytics for -
		  • evaluating the APM
		  • evaluating the Boards regulatory activities
			5/11/2021 -- Scheduled

5	**Emma Harrigan**, *VAHHS* **Lauri Scharf**, *BiState Primary Care Assoc.* **Thomasena E Coates**, *Blueprint QI Facilitator*	• Point of care support	**6/1/2021 -- Scheduled**
6	**Lisa Schilling**, *Medicaid Operation* **Erin Carmichael**, *Medicaid Quality* **Shawn Skaflestad**, *Medicaid Performance Management/Improvement* **Tim Tremblay**, *Vermont Blueprint for Health*	• Quality Improvement and Reporting for Medicaid and the Blueprint • Overall evaluation of GC1115 waiver	***TBD*** **– Scheduled**